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Homeless reduction act in England: impact on health services

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The Homeless Reduction Act,¹ an act of the UK Parliament that legally mandates city authorities and health service providers to provide anticipatory and corrective measures for the reduction of homelessness, came into force in England in April, 2018. It places new legal duties on English city councils (legislative bodies that govern a city) and the National Health Service (NHS) to enable strengthened homeless prevention and management work across partners.

Among the changes for local authorities is the mandate to act early in offering support to those threatened with homelessness and providing free homelessness advice and information. The act requires that health-service providers have an active role in the prevention and management of homelessness. There is a duty on these services to refer service users they consider may be homeless or threatened with homelessness to a local public housing authority of the city council who will be responsible for supporting them with appropriate assistance.² The duty to refer comes into force from October, 2018.

There is now an impetus for health services in England to develop effective mechanisms to identify and refer homeless and vulnerably housed people. For example, hospitals are expected to formulate and implement formal admissions and discharge protocols so that an appropriate mechanism for referral and transition of care is agreed with local housing authorities during the patient's stay in the hospital. A few examples of such practices already exist in England. Homeless pathway coordinators offer support to local hospitals for post-discharge planning and avoid discharging homeless patients when they know they have nowhere to go.³ Services to identify and effectively manage repeat attenders of emergency departments in liaison with homeless outreach teams, primary care services, and local authorities have also been piloted.⁴ Such projects aim to reduce the number of accident and emergency attendances,⁴ although rigorous academic evaluations are not available. In some primary care practices, homeless patients have been given "my right to access healthcare cards"⁵ that allow them to register and seek care. Staff have also been trained on access to health care for patients with no fixed abode.⁶

The implementation of the act, however, will present challenges. Hospitals will need support from care navigators who know the complex wider support available to homeless people in the local area. These services are not always interlinked. Health-care providers and social services face difficulties in recruiting staff who have relevant skills and are able to engage with homeless people. In addition, many patients are caught up in a repeat cycle of homelessness and ascertaining their eligibility for support is usually complicated.

In primary care and urgent walk-in facilities, where patient contact time is often limited, different skill sets will be required to address the complex needs of homeless people. Our research shows that health-care staff in primary care facilities often find it challenging to broach the subject of homelessness with the patients.⁷ Such reluctance can arise from insufficient clarity about the remit of staff in helping the homeless and inadequate guidelines and knowledge about local support available to the homeless patients. Additionally, homeless patients often change their localities with their primary care providers. Hospital readmissions in different locations make it difficult to provide seamless care. Joined up working across different sectors of health and social care is essential, for example, in sharing information and providing long-term follow-up. Many factors, often in various combinations, can lead to homelessness, including relationship breakdown, being asked to leave the family home, drug and alcohol addiction, leaving prison, mental health problems, eviction, debt and poverty, and problems with benefits payments.⁸ The act is a positive move;

however, large-scale system change is also required. Homelessness in the UK is increasing, particularly in urban areas.⁹ Over twice as many people slept rough in London, UK, in 2017, compared with 2011 (1137 vs 446).¹⁰ Homelessness priorities at the government level¹¹ should continue to further connect to a range of social policies in housing, employment, skills, and health. The impact of long-term austerity and welfare reforms should also be addressed by reducing social and economic inequalities as outlined in Marmot review.¹²

Scaling up of services that can manage complex health and social care needs of homeless people should be a priority. This population is affected by persistent health inequalities. Injury, poisoning, and external causes are the leading cause of death among homeless people in high-income countries.¹³ Services to prevent and manage substance use, mental illness, and communicable diseases can be better linked with each other, and where possible provided under the same roof. Improving the skill mix of health-care staff so that they can provide tailored support to this vulnerable population is equally important. Good rapport between health-care staff and clients enables homeless people to value and access available services.¹⁴ This act has the potential to contribute to the strengthening of such relationships.

How health services and local authorities work together in implementing the act will be of wider interest. They must invest in time and training to ensure front-line staff fully adopt the new service culture to “make every contact count”.¹⁵ It will be in the interest of wider stakeholders to evaluate health impacts, readmissions, discharge time, health-care costs, and extent of patient engagement and satisfaction with the services that will come in response to the act. By making homeless prevention a statutory duty and mandating earlier intervention, this act is welcome and could be instructive for other countries. Necessary organisational and financial support is imperative to allow services to effectively prevent and manage homelessness.

We declare no competing interests.

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